Be dental
cosmetic, general and implant solutions

CONFIDENTIAL INFORMATION

Please complete your personal information as accurately as possible so that we can provide you with the best and safest dental care.

Please Circle – Dr Mr Mrs Ms Miss Master

First Name: _____ Surname: _____

Preferred Name: _____

Date of Birth: _____

Address: _____

_____. Postcode: _____

Preferred Contact number/s: _____

Email: _____

Occupation: _____

Emergency Contact Name: _____ Ph: _____

Private Health Fund: Yes / No: If yes, which fund? _____

How did you discover our Practice? _____

CONFIDENTIAL MEDICAL HISTORY

Have you had or currently have any of the following?

	YES	NO		YES	NO
Steroid Therapy			Nervous/Anxiety Condition		
Rheumatic Fever			Tuberculosis		
Epilepsy			Thyroid Disease		
Asthma			Radiation Therapy		
Diabetes			Stomach or Digestive Condition (e.g. Reflux)		
Heart Valve Disorder			Transplanted Organ or Bone Marrow		
Stroke			Kidney Disease		
Heart Murmur			Excessive Bleeding		
Cardiac Pacemaker			Hepatitis A B C (please circle)		
Eating Disorder			Liver Disease		
Heart Complaint or Surgery eg Bypass Operation			Blood Disorder		
High or Low Blood Pressure (please circle)			Confirmed/Suspected contact with HIV/AIDS Virus		
Anaemia			Bronchitis. Emphysema or other Lung Disease		
Cancer			Prosthetic Implant (e.g. Prosthetic Hip or Knee)		
Do you smoke			Pregnant		
Denture			Fainting/Dizzy Spells		

Any Medical Conditions/Treatment or Medications other than those listed above?

_____

Name of Medical Practitioner: _____

Do you have or have you ever had bone disease? _____

(e.g. Osteoporosis, Paget's Disease, Multiple Myeloma, Cancer which spread to bones)

Are you taking or have you taken in the past **Bisphosphonate** medications? _____(e.g. Alendronate, Risedronate, Pmidronate, Zoledronate, Tiludronate, Etidronate, Clodronate, Fosamax, Actonel, Zometa, Aredia, Pamisol)

- Do you have any known allergies? Yes / No
- If yes, please list _____
- When was your last dental visit? _____
- Last dental x-rays? _____
- Does your jaw “click” or hurt? Yes / No
- Do you feel you grind your teeth? Yes / No
- Have you ever had teeth break/chip? Yes / No
- Have you ever had orthodontic treatment? Yes / No
- Have you ever had periodontal (gum) disease? Yes / No
- Do you think you have occasional bad breath? Yes / No
- Do your gums ever bleed when you clean your teeth? Yes / No
- Do you experience sensitivity with hot/cold? Yes / No
- Does floss ever tear between your teeth? Yes / No
- Does food get jammed between your teeth? Yes / No
- Do you consent to sharing records with dental specialists? Yes / No
- Is there anything else you would like us to know? Yes / No

Other: _____

Dental photographs will often be taken to assist in provision of your treatment.

Do you consent for your dental images to be utilised anonymously? :

- In the education of other patients Yes / No
- On social media Yes / No

Keep up to date with us!!

 bedental_  Be Dental Arundel Plaza

We request and expect payment at the time of treatment.
For your convenience we accept Cash, Cheque, Eftpos, Visa, MasterCard and Amex.

In order to avoid a cancellation fee, we require 48 hours notice to reschedule an appointment. By signing this form you agree to these terms and conditions.

Patients/Guardians Name: _____

Patients/Guardians Signature: _____ **Date:** _____